EMI HEALTH™

**Administered by Educators Mutual Insurance Association**
**EMI Health Customer Service 801-262-7475 or 1-800-662-5851**
Self Funded Employee Medical Benefit Plan

**All services are subject to the EMI Health Maximum Allowable Charge. When using a Non-participating Provider, the Covered Person is responsible for all fees in excess of the Maximum Allowable Charge.**

| EMIA Pool<br>September 01, 2021 - August 31, 2022<br>PHD3000 QHDHP | Care Plus | |
|---|---|---|
| | Participating Provider Option | Non-Participating Provider Option |
| **GENERAL INFORMATION** | **YOU PAY** | |
| Benefit Accumulator | Contract Year | |
| Dependent Age Limit | 26 | |
| Out-of-Pocket Maximum (Per Person/Family Per Year) | $4,500 / $9,000 | $5,500 / $11,000 |
| Medical Deductible (Per Person/Family Per Year). Please note ♦ | $3,000 / $6,000 | $4,500 / $9,000 |
| Non-Preauthorization Patient Penalty | Not Applicable | 50% Reduction in Benefits |
| Non-Preauthorization Provider Sanction | 50% Reduction in Payment | Not Applicable |
| **PRESCRIPTION DRUG BENEFITS (If brand is purchased when generic is available, member pays the copay plus the difference between the generic and the brand price)** | **YOU PAY** | |
| Participating Pharmacy (30 day supply) | ♦Generic - 10%<br>♦Preferred - 30%<br>♦Non-Preferred - 50% | |
| Non-Participating Pharmacy | Not Covered | |
| Mail Order (90 day supply) | ♦Generic - 10%<br>♦Preferred - 30%<br>♦Non-Preferred - 50% | |
| Specialty Pharmacy SaveOnSP Program 1-800-683-1074<br>http://emihealth.com/pdf/saveon.pdf | Must enroll to receive:<br>*$0 Copay | |
| **PREVENTIVE SERVICES** | **YOU PAY** | |
| Routine Physical Exam (1 visit per Year) | Covered 100% | Not Covered |
| Routine Gynecological Exam (1 visit per Year) | Covered 100% | Not Covered |
| Family History Exam (1 visit per Year) | Covered 100% | Not Covered |
| Routine Pap Smear & Mammogram (1 per Year) | Covered 100% | Not Covered |
| Routine Well-Baby Exams | Covered 100% | Not Covered |
| Covered Immunizations | Covered 100% | Not Covered |
| Routine Vision Exam (1 visit per Year) | Covered 100% | Not Covered |
| Routine Hearing Exam (1 visit per Year) | Covered 100% | Not Covered |
| **PHYSICIAN & PROFESSIONAL SERVICES** | **YOU PAY** | |
| Physician Office Visits (primary care) | ♦20% | ♦40% |
| Physician Office Visits (secondary care) | ♦20% | ♦40% |
| Physician Office Visits (after hours) | ♦20% | ♦40% |
| Physician Visits (Inpatient) | ♦20% | ♦40% |
| Physician Visits (Outpatient) | ♦20% | ♦40% |
| Major Diagnostic Test, CT Scan, MRI, NMR (office) | ♦20% | ♦40% |
| Minor Diagnostic Test, Radiology, Lab (office) | ♦20% | ♦40% |
| Minor Diagnostic Test, Radiology, Lab (Inpatient) | ♦20% | ♦40% |
| Minor Diagnostic Test, Radiology, Lab (Outpatient) | ♦20% | ♦40% |
| Injections (office) | ♦20% | ♦40% |
| Surgery (office) | ♦20% | ♦40% |
| Surgery (Inpatient) | ♦20% | ♦40% |
| Surgery (Outpatient) | ♦20% | ♦40% |
| Anesthesiology (office) | ♦20% | ♦40% |
| Anesthesiology (Inpatient) | ♦20% | ♦40% |
| Anesthesiology (Outpatient) | ♦20% | ♦40% |
| Routine Prenatal & Delivery (Dependent maternity included) | ♦20% | ♦40% |
| Home Health and Hospice Care (in lieu of Hospital) (for supplies, see Medical Supplies and Equipment) | ♦20% | ♦40% |
| Rehabilitation Therapy (Outpatient physical, speech, occupational, cardiac, or pulmonary - 20 visits per Year per injury/illness) | ♦20% | ♦40% |
| Chiropractic Therapy (20 visits per Year) | ♦20% | ♦40% |
| Allergy Testing | ♦20% | ♦40% |

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|---|---|---|
| | Participating Provider Option | Non-Participating Provider Option |
| Allergy Treatment/Serum | ♦20% | ♦40% |
| **HOSPITAL/FACILITY BENEFITS**<br>(Physician & Professional Services are not included in this section.) | **YOU PAY** | |
| Medical/Surgical/Maternity/Intensive Care (semi-private room) | ♦20% | ♦40% |
| Medical/Surgical/Maternity/Intensive Care (Inpatient Ancillary) | ♦20% | ♦40% |
| Skilled Nursing Facility (30 days per Year) (Admission must be within 5 days of discharge from Hospital Confinement) | ♦20% | ♦40% |
| Medical/Surgical Care (Outpatient) | ♦20% | ♦40% |
| Emergency Room (ER) | ♦20% | ♦20% |
| Major Diagnostic Test, CT Scan, MRI, NMR (Outpatient) | ♦20% | ♦40% |
| Minor Diagnostic Test, X-ray, Lab (Inpatient) | ♦20% | ♦40% |
| Minor Diagnostic Test, X-ray, Lab (Outpatient) | ♦20% | ♦40% |
| Newborn | ♦20% | ♦40% |
| InstaCare/Urgent Care Clinic | ♦20% | ♦40% |
| Eligible Preventive Services | Covered 100% | Not Covered |
| **REHABILITATION THERAPY BENEFIT** | **YOU PAY** | |
| Inpatient – physical, speech, occupational, cardiac, or pulmonary (40 days per person per Year) | ♦20% | ♦40% |
| **ACCIDENT AND LIFE THREATENING CONDITION** | **YOU PAY** | |
| Medical/Surgical – Physician/Facility/ER | Covered as any other condition | Covered as a Participating Benefit to the Maximum Allowable Charge |
| Ambulance Land/Air (Accident & Life-threatening) | ♦20% | |
| Orthodontic Injury Treatment | ♦20% | |
| Dental Injury Treatment | ♦20% | |
| **TRANSPLANT BENEFIT** | **YOU PAY** | |
| Heart, Liver, Pancreas, Bone Marrow, Cornea, Lung, Kidney | Covered as any other condition | Not Covered |
| **MEDICAL SUPPLIES & EQUIPMENT** | **YOU PAY** | |
| Diabetic Testing Supplies (90 day supply) | ♦30% | ♦40% |
| Medical Supplies | ♦20% | ♦40% |
| Medical Supplies (office) | ♦20% | ♦40% |
| Durable Medical Equipment/Prosthetics/Orthotic Devices | ♦20% | ♦40% |
| Hearing Aids ($2,500 per Year) | ♦20% | ♦40% |
| Orthotic Supplies (foot inserts & arch supports) | Not Covered | Not Covered |
| Growth Hormone | Not Covered | Not Covered |
| **MENTAL HEALTH & DRUG/ALCOHOL TREATMENT** | **YOU PAY** | |
| Inpatient Facility | ♦20% | ♦40% |
| Inpatient Physician Visits | ♦20% | ♦40% |
| Residential Treatment (30 days per year) | ♦20% | ♦40% |
| Outpatient Facility | ♦20% | ♦40% |
| Physician Office Visits<br>Psychologist / LCSW / APRN / Psychiatrist | ♦20% | ♦40% |
| **ADDITIONAL BENEFITS** | **YOU PAY** | |
| Adoption Indemnity Benefit | The Plan pays a maximum of $4,000 towards adoption expenses. | |
| TMJ Syndrome diagnosis & non-surgical treatment | ♦20% | Not Covered |
| Orthognathic/Mandibular Osteotomy | ♦20% | Not Covered |
| Total Parenteral Nutrition (TPN) | ♦20% | Not Covered |
| Initial assessment and diagnosis of Primary Infertility | ♦20% | Not Covered |
| Reduction Mammoplasty | ♦20% | Not Covered |
| Autism Applied Behavior Analysis | ♦20% | ♦40% |

Services designated ♦ are subject to first dollar Medical Deductible

Services designated *, premiums, balance-billed charges, charges for services this Plan doesn't cover, amounts in excess of benefit limits, and penalties for failure to obtain Preauthorization, do not accumulate toward your Out-of-pocket Maximum.

| PROVIDER NETWORK | |
|---|---|
| Utah | EMI Health Care Plus |
| Outside of Utah | Cigna PPO |

PLEASE NOTE: This is a summary only and does not guarantee benefits. All benefits are subject to the terms, limitations, and exclusions set forth in the Plan document and in the Summary Plan Description (SPD)/handbook of the Plan. Any discrepancies between this summary, the SPD/handbook, and the Plan document are resolved in favor of the Plan document. For more information, including Preauthorization, refer to the SPD/ handbook or the Plan document, or contact EMI Health Customer Service Department.